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Rectal tuberculosis: A rare cause of recurrent rectal suppuration

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Abstract

Tuberculosis affecting the rectum is a rare extra-pulmonary form of the disease that needs recognition, because it requires specific treatment and avoids multiple, unwarranted surgical interventions. The following discussion is centred on a case of rectal tuberculosis, a disease that rarely affects the anorectal region. The condition was diagnosed on histology and was successfully treated medically with complete resolution.

Introduction

There are many causes of chronic anorectal suppuration, the common causes being, Crohn's disease, venereal disease, neoplasia and foreign body reactions [1]. As the incidence of tuberculosis in the West is slowly rising, and also HIV-related infections are becoming more prevalent, the awareness of tuberculosis affecting the anorectal region should be borne in mind in the management of recurrent anorectal fistulas, ulcers and abscesses.

Case report

A 41-year-old male was referred with a history of recurrent intra-rectal abscess. Each time, the patient had complained of intra-rectal pain and purulent discharge per-rectum, he had undergone per-rectal drainage six times over a period of 6 months. He had no history of altered bowel habits, evening pyrexia, cough, haemoptysis or contact history of tuberculosis. He had no anorexia but had lost 7 kg since the onset of the illness.

On examination, he looked thin but not pale. There was no cervical lymphadenopathy. Examination of the cardiovascular, respiratory systems and the abdomen was unremarkable. The ESR was 61 mm after the first hour. Mantoux was strongly positive, being 15 mm. Chest radiograph was normal while the sputum and urine microscopy was negative for acid fast bacilli (AFB). Serology for HIV and VDRL was also negative. Flexible sigmoidoscopy showed an irregular, undermined ulcer on the posterior wall of the rectum. When examined under anaesthesia, an undermined ulcer communicating with an inter-sphincteric abscess was found at 6 o'clock position in distal rectum. A segment of the ulcer edge was excised and the floor of the abscess cavity was scooped and sent for histology and PCR. Histology showed chronic granulomatous inflammation and caseation, suggestive of tuberculosis. However, the Ziehl-Nielsen test for AFB and the PCR were both negative on the biopsy specimen. The patient was referred for further management, where anti-TB drugs were commenced. Six months since starting therapy, he remains asymptomatic and the repeat flexible sigmoidoscopy showed complete healing of the ulcer.

Discussion

Anorectal tuberculosis is a rare extrapulmonary form of the disease. It is known to be usually associated with pulmonary lesions, although isolated rectal lesions in the absence of systemic involvement have been reported [2].

Table 1 Previous literature on presentation and outcome of rectal tuberculosis

Authors	Article
Sahoo D, Mapatra MK, Salim S	Trop Gastroenterol 2004;25(2):84–5
Dumitruscu DL, Trocan A, Dumitra D *et al.*	Rom J Gastroenterol 2003;12(3):235–8
Chung CK, Meng WCS, Thomas TMM *et al.*	ANZ J Surg 1999; 69(11): 828–9
Puri AS, Vij JC, Chaudhary A *et al.*	Dis Colon Rectum 1996; 39(10): 1126–29
Menezes NN, Waingankar VS *et al.*	JPGM 1989; 35(2): 118–9

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These patients may present with, pain in the rectum, recurrent fistula in-ano, purulent discharge per-rectum, bleeding per-rectum, constipation, diarrhoea or constitutional symptoms [Table 1]. Examination usually reveals an ulcer, stricture or nodularity in the involved segment [3]. It is possible to arrive at the diagnosis with the help of endoscopy and histology supplemented by ESR, Mantoux test and CRP. Histological demonstration of chronic granulomatous inflammation with caseation is pathognomonic of tuberculosis. Culture or demonstration of AFB in the biopsy specimen using Zhiehl-Nielson stain is the most specific test, although in most instances superficial biopsies may not reveal the bacilli [3] and only 36% of the cultures would yield a positive result [4]. Anorectal tuberculosis usually responds well to antitubercular drugs and these patients seldom require any further surgical intervention.

It is therefore important that we learn to recognize this entity in a patient with recurrent anorectal sepsis (i.e. fistula/abscesses) as it requires specific treatment which leads to a complete cure. Lack of suspicion in such a case can lead to delay in the diagnosis, subjecting the patient to repeated investigations and multiple interventions which may result in stricturing and even anal sphincter damage resulting in anal incontinence. Although tuberculosis is rare in the West, considering the migration to the West by people from countries with a high prevalence, rectal tuberculosis should be considered in those who present with recurrent rectal or perianal sepsis.

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Radiation-induced angiosarcoma of the rectum: a case report and review of literature

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Abstract

We report a case of rectal angiosarcoma after prostatic radiotherapy, illustrating diagnostic difficulty. Awareness of this potential diagnosis is important with increasing use of radiotherapy in the treatment of pelvic cancers.

Case history

A 74-year-old male presented with severe anal pain and bleeding. He had had radiotherapy for prostate cancer 8 years previously and was in a stable state. Digital rectal examination revealed a hard indurated mass in the upper anal canal, flexible sigmoidoscopy and biopsy were performed. The biopsy showed prominent vascularity which was considered to be a reactive process. Because of the previous malignancy and a high clinical suspicion he underwent computed tomography (CT) and magnetic

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